Side-by-Side Comparison of EPSDT, USPSTF, & AAP

(Considering their respective orientation, intent, organization, target population, and limitations)

	EPSDT	USPSTF	AAP
Orientation & Intent	Developed at a policy level to ensure coverage & payment for children's preventive care services. Although it refers to particular services, was not intended as definitive source of clinical recommendations.	Developed to document collective state of evidence with regard to specific clinical preventive services; and to recommend services based on strength of that evidence. Does not speak to matters of coverage or payment.	Developed to communicate specific clinical preventive service recommendations for children. Does not speak to matters of coverage or payment.
Source of Recommendations	Not an original source of clinical recommendations. Relies on other sources, such as AAP, to infer what should be included for coverage / payment.	Recommendations come from analysis of research by USPSTF, including meta-analyses, and information and data from additional national and international sources.	Recommendations represent consensus of AAP's Committee on Practice & Ambulatory Medicine, in consultation with other national groups & AAP sections. Existing evidence is reviewed & interpreted to develop consensus recommendations.
Target Population	Focused on low-income children, birth through adolescence, who are eligible for publicly subsidized health insurance such as Medicaid.	Focused on the general population, with some reference to services for high risk sub-populations. Includes recommendations for children, but is not specific only to children.	Focused on the general population, with some reference to services for high risk sub-populations. Recommendations are specifically for children and are age-specific.

Addendum (cont'd.):

Side-by-Side Comparison of EPSDT, USPSTF, & AAP

(Considering their respective orientation, intent, organization, target population, and limitations)

	EPSDT	USPSTF	AAP
Organization	Generally organized by categories of services (such as immunizations, or comprehensive physical exam). Suggests some specific services & timing of visits, but is less clinically specific than USPSTF or AAP.	Generally organized by categories of screening, counseling, and intervention. Greater specificity in its clinical recommendations than EPSDT. Not focused on periodicity or timing.	Organized by age / timing of periodic visits and by categories (history, measurements, sensory screening, physical exam, developmental assessment, , procedures, anticipatory guidance, & dental referral).
Limitations	--Originally developed in 1967 with provisions added in 1989 as a list of covered services. --Not necessarily using an evidence-based method for deciding to cover services. --Low-income / potentially high-risk population focus. --Not intended as source of clinical recommendations.	--Last updated in 1996; more current evidence under review for 3rd edition. --Although comprehensive & inclusive in scope of topics, does not address delivery of children's preventive services in terms of periodicity. --Limits of evidence-based model: Potentially effective services not meeting this framework are not included for review. Insufficient evidence results in recommendation neither for nor against a service, but **"does not constitute evidence of ineffectiveness".** (USPSTF, 2nd ed.; 1996; pg. lii).	--Most current of these sources, published in 2000. (Previously version 1995.) --Rigor of evidence review is less apparent. Recommendations consider evidence, but ultimately determined by consensus.